TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Gulf Coast Medical Center

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-4182-011

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Therefore, we wish to appeal this decision and submit detailed information regarding the treating physician's decision in regards to treatment and the most recent medical, technical and scientific evidence involved in developing the treatment plan."

Amount in Dispute: $906.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is nothing in that statement or in the requestor's documentation that meets the definition of a medical emergency at Rule 133.2."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2015	Outpatient Hospital Services	$906.26	$326.26

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines emergency
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule that determines reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $906.26 for emergency medical services rendered on June 18, 2015. The insurance carrier denied disputed services with claim adjustment code 899 – "Documentation and file review does not support an emergency in accordance with Rule 133.2."

   28 Texas Administrative Code §133.2 (5) states,

   > Emergency--Either a medical or mental health emergency as follows:
   >
   > > (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:
   > >
   > > (i) placing the patient's health or bodily functions in serious jeopardy, or
   > >
   > > (ii) serious dysfunction of any body organ or part;

   Review of the submitted medical documentation finds:

   - Emergency Physician Record – Associated symptoms: severe numbness tingling
     - Exacerbated by "movement arm and hand"
     - Relieved by nothing
   - Emergency Nursing Record – Page 1 of 2
     - Pain Level: 8
     - Additional findings: "Pt states she was doing repetitive motions @ job and pain got worse"

The Division found in review of the submitted medical documentation the definition requirements of Rule 133.2 met. Specifically, "severe numbness tingling" and "Pain Level 8."

The Division finds carrier's denial not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. The services in dispute are outpatient hospital services and are subject to provisions of 28 Texas Administrative Code §134.403. The relevant portions are found below:

   > (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise
   >
   > > (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
   >
   > (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.
   >
   > (f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

The resources that define the components used to calculate the Medicare payment for OPPS are found below:

- **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
  - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

Based on the above the maximum allowable for the services in dispute is calculated below:

Procedure Code	Status Indicator	APC	Payment Rate	60% labor related	2015Wage Index Adjustment for provider 0.9679	40% non-labor related	Payment	Maximum allowable reimbursement
99282	V	613	$112.79	$112.79 X 60% = $67.67	$67.67 X 0.9679 = $65.50	$112.79 X 40% = $45.12	$65.50 + $45.12 = $110.62	$110.62 X 200% = $221.24
96372	S	437	$53.54	$53.54 X 60% = $32.12	$32.12 X 0.9679 = $31.09	$53.54 X 40% = $21.42	$31.09 + $21.42 = $52.51	$53.54 X 200% = $105.02
							Total	$326.26

3. The total allowable reimbursement for the services in dispute is $326.26. This amount recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $326.26.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $326.26, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		December 22, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.